

STATE OF MICHIGAN
IN THE SUPREME COURT

COVENANT MEDICAL CENTER,

Plaintiff-Appellee,

Supreme Court No. 152758

v.

Court of Appeals No. 322108

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY, a Michigan
insurance corporation,

Saginaw County Circuit Court
No. 13-020416-NF

Defendant-Appellant.

_____ /

BRIEF OF AMICI CURIAE,
INSURANCE INSTITUTE OF MICHIGAN AND
MICHIGAN INSURANCE COALITION,
IN SUPPORT OF DEFENDANT-APPELLANT'S
APPLICATION FOR LEAVE TO APPEAL

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STATEMENT OF THE QUESTIONS PRESENTED

1. Should the Court grant review in this case to determine whether healthcare providers possess a right to enforce a no-fault insurer's obligations to pay personal protection insurance benefits?

The Amici Curiae, Insurance Institute of Michigan and Michigan Insurance Coalition, answer, "Yes."

2. Notwithstanding whether a healthcare provider is otherwise vested with a right to pursue a direct action on a claim for the payment of no-fault benefits owed by an insurer, should the Court grant review in this case to determine whether such an action would remain dependent on the insurer being obligated to pay benefits to the provider on behalf of the insured, such that a release of claims or other resolution of the insured's rights against the insurer would bar the provider's claim?

The Amici Curiae, Insurance Institute of Michigan and Michigan Insurance Coalition, answer, "Yes."

INTEREST OF AMICI CURIAE

On behalf of their member companies, the Insurance Institute of Michigan (“IIM”) and the Michigan Insurance Coalition (“MIC”) are interested in the very significant issues raised in the case at bar. At issue, specifically, is whether Michigan no-fault insurers and the injured persons they insure will remain able to negotiate and resolve contested claims for benefits efficiently and with a minimum of litigation. It is beyond dispute that their ability to do so is essential to the No-Fault Act’s basic goals of relieving the overburdened court system and remedying the long delays in payment that were so commonplace in the tort system it replaced. *McCormick v Carrier*, 487 Mich 180, 189; 795 NW2d 517 (2010), quoting, *Shavers v Attorney General*, 402 Mich 554, 579; 267 NW2d 72 (1978); see also, *US Fidelity & Guaranty Ins Co v MCCA*, 484 Mich 1, 25; 795 NW2d 101 (2009).

The decision of the Court of Appeals in this case is inimical to these goals. If left unaltered, the new procedures established by the Court’s published opinion virtually eliminate the ability of parties to settle even the simplest of no-fault claims without judicial intervention. The issues raised by these rulings, Amici Curiae submit, are of extreme jurisprudential significance and should be reviewed by this Court.

IIM represents over 90 property/casualty insurance companies and related organizations operating in Michigan. Its member companies provide insurance to approximately 75% of the automobile market in Michigan and are interested in the ongoing development of automobile no-fault and liability insurance in Michigan. Similarly, MIC is a state property-casualty trade association based in Lansing, Michigan. Its members are

insurers who annually underwrite more than \$3 billion in insurance premiums in Michigan. Most of MIC's member insurers have their national headquarters located in Michigan.

The application for leave to appeal submitted by Defendant-Appellant, State Farm Mutual Auto Insurance Company, raises issues that are of great importance to both the insurance industry and Michigan's purchasers of mandatory automobile insurance, and accordingly, to the Amici Curiae, IIM and MIC.

INTRODUCTION

When the Court of Appeals issued its published opinion in *Covenant Medical Center, Inc v State Farm Auto Ins Co*, __ Mich App __; __ NW2d __ (No. 322108, October 22, 2015), it sent shockwaves through the no-fault insurance world. On that date, four decades of established no-fault claim handling and litigation practice, under which claims for personal protection insurance benefits routinely were negotiated and resolved directly with the injured person entitled to the benefits, was fundamentally dismantled.

Relying on §3112 of the No-Fault Act, MCL 500.3112, the Court of Appeals held that an insurer's "payment" of settlement monies to the injured person, pursuant to a negotiated resolution and binding agreement for "release" of the injured person's claims, leaves the insurer exposed, post-settlement, to direct claims of the injured person's healthcare providers. According to the Court of Appeals' opinion, this post-settlement exposure exists if, at the time of settlement, the insurer was in possession of a provider's bill for services rendered yet failed to notify the provider of the intended "payment" and obtain a circuit court order apportioning distribution of the settlement proceeds. *Covenant Medical*, slip op at 2-3.

As a consequence of the new procedures required by §3112 as construed in *Covenant Medical*, reports of the following dilemmas are now commonplace:

- Circuit court PIP actions now cannot be finalized for several weeks or even months after a settlement is reached due to the parties having to identify all medical and other service providers, prepare, file and give notice of a “3112 motion,” appear for an “apportionment” hearing, and issue payment(s) in accord with the court’s ruling, all at significant time and expense to the litigants and the courts;
- Uncertainty as to what constitutes “notifi[cation] in writing of the claim of some other person” [§3112] causes insurers to err on the side of inclusion when giving notice of a 3112 settlement hearing; this, in turn, has a “poking the hornet’s nest” effect that has increased the number of providers filing suit or intervening into an existing suit;
- The overall number of motions being heard on circuit courts’ weekly motion calls has increased dramatically, as virtually every settlement of a PIP action now requires an apportionment hearing;
- Due to inconsistency among circuit court judges in how they view the §3112 apportionment process and its requirements, it is never certain from the litigant’s perspective that its motion will be granted (and where does it leave the settling parties if the motion is “denied”?), that the motion will finally resolve the matter, or that it will even be heard;
- When the action to be settled is pending in district court, motions for apportionment are being rejected since §3112 gives authority to hold such hearings only to circuit courts; parties in such instances, *and those attempting to settle a claim pre-suit*, perceive no alternative but to initiate new proceedings in circuit court.

In short, the imposition of these mandatory procedures effectively eliminates the ability of parties to settle their contested no-fault claims efficiently and with a minimum of litigation.

What is more, the analysis on which the Court of Appeals based these new procedural requirements is demonstrably flawed. It fundamentally misreads MCL 500.3112 and, as a consequence, not only applies §3112 to circumstances that in fact are not governed by the provision, but also confers a brand new right of immunity on healthcare providers—a right to avoid the consequences of the bars of “release” and *res judicata*—thereby expanding on the already tenuous “right” previously conferred by the Court of Appeals allowing healthcare providers to bring direct claims against their patient’s no-fault insurers in the first place.

This brief will show, first, that the essential premise on which the Court of Appeals’ holding is based is insupportable. Hospitals, physicians, and other healthcare and service providers do not, after all, have any viable legal basis for suing no-fault insurers to enforce an injured person’s entitlement to PIP benefits. And second, even if one were to accept the premise that providers have a right to sue an insurer for payment of the insured’s service bills, any such right is inherently derivative of and dependent upon the insured having a valid claim for benefits; and contrary to the Court of Appeals’ holding, no right to avoid the barring effect of release or *res judicata* is conferred on providers by §3112.

For the following reasons, Amici Curiae IIM and MIC submit that the Court should grant Defendant-Appellant’s application for leave to appeal.

ARGUMENT

I. THE *COVENANT MEDICAL* HOLDING IS FATALY DEPENDENT ON THE INSUPPORTABLE PREMISE THAT HEALTHCARE PROVIDERS POSSESS THE RIGHT TO ENFORCE AN INSURER'S OBLIGATIONS UNDER THE NO-FAULT ACT.

In its relatively brief opinion, the Court of Appeals in *Covenant Medical* quotes, with selected emphasis, most of §3112 of the No-Fault Act, MCL 500.3112, endeavoring to apply “the plain and ordinary meaning of the language of the statute[.]” Slip op at 2, quoting *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins*, 250 Mich App 35, 37; 645 NW2d 59 (2002). The portion highlighted by the Court is §3112's second sentence:

“... Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.”

Covenant Medical, slip op at 2 (emphasis in original). By its terms, the statute proceeds from this point to permit an insurer, or any other interested person, to apply to the circuit court for an order equitably apportioning the payment of benefits “if there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto[.]” §3112 (third sentence).

Based on these provisions, the Court of Appeals held that an insurer must seek circuit court intervention, with notice to any healthcare provider whose written notice of “claim” has been received by the insurer, to obtain an order apportioning “payment” of the agreed-upon settlement between the insurer and the injured person. Failure to do so, the Court held,

leaves the insurer liable for the “claim” of any such healthcare provider that was not included in the apportionment hearing process. *Covenant Medical*, slip op at 2-3:

[T]he plain text of the statute provides that if the insurer has notice in writing of a third party’s *claim*, then the insurer cannot discharge its *liability to the third party* simply by settling with its insured. Such a payment is not in good faith because the insurer is aware of a *third party’s right* and seeks to extinguish it without providing notice to the affected third party. Instead, the statute requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated. That was not done in this case. Accordingly, pursuant to the plain language of the statute, because State Farm had notice in writing of Covenant Medical’s *claim*, State Farm’s payment to Stockford [the injured person] did not discharge its *liability to Covenant Medical*.

Id. (emphasis added).

As the italicized words in the above quotation plainly reveal, the Court of Appeals’ holding, along with the myriad new time and expense consuming procedures it mandates, is founded on the premise that a healthcare provider such as Covenant Medical Center possesses a third party “right” to assert against the injured person’s no-fault insurer; that it does, in fact, have standing to pursue a viable “claim” for which the insurer bears “liability to the third party” healthcare provider.

This fundamental premise is invalid. The authorities cited by the Court of Appeals for the proposition that healthcare providers possess such rights demonstrably fail to support the premise. As a matter of contract law, healthcare providers are neither parties to, nor intended third-party beneficiaries of, the no-fault insurance policies on which they would base their “claims”; and while §3112 irrefutably does render non-contracting “injured persons” and “dependents” of fatally injured persons intended third-party beneficiaries of any

no-fault insurance policy, it manifestly does *not* do so with respect to healthcare providers or others who might incidentally benefit from an injured person's insurance coverage.

There is, therefore, no contractual basis for service providers to pursue recovery of benefits from no-fault insurers; and neither §3112 nor any other provision in the No-Fault Act creates a statutory cause of action allowing them to do so. Absent either a statutory or non-statutory ground on which to base a claim, a healthcare provider simply has no legally viable "claim" enforceable against the no-fault insurer; and absent this essential premise, the holding in *Covenant Medical* cannot stand.

- A. The authorities cited by *Covenant Medical* for the proposition that healthcare providers have a viable "claim" to assert against no-fault insurers ultimately fail to support the premise.

The holding in *Covenant Medical* is dependent on the proposition that one who provides healthcare services to a motor vehicle accident victim has standing to assert a "claim" against the person's no-fault automobile insurer to compel payment of benefits on behalf of the insured. As in prior cases, the Court of Appeals proceeded on the assumed premise, based loosely on MCL 500.3112 but more so on passing statements and assumptions made in earlier Court of Appeals opinions, that providers do possess direct claims of their own against no-fault insurers.

Thus, in response to the argument that the injured party's release of claims against the insurer necessarily precluded Covenant Medical Center from suing State Farm, the Court of Appeals, with citations of authority, stated:

[I]t is also well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of

no-fault benefits. *Wyoming Chiropractic Health, PC v Auto-Owners Ins Co*, 308 Mich App 389, 396-397; ___ NW2d ___ (2014); *Moody*, 304 Mich App at 440; *Mich Head & Spine*, 299 Mich App at 448 n 1; *Lakeland Neurocare Ctrs*, 250 Mich App at 42-43; *Regents of Univ of Michigan v State Farm Mut Auto Ins Co*, 250 Mich App 719, 733; 650 NW2d 129 (2002).

Covenant Medical, slip op at 3. It turns out, upon closer examination, that this “well settled” premise is utterly unsupported.

The opinion first cited, *Wyoming Chiropractic Health, PC v Auto-Owners Ins Co*, 308 Mich App 389; 864 NW2d 598 (2014), *lv den*, 497 Mich 1029 (2015), does not itself analyze §3112 (or any other section of the No-Fault Act) as establishing a cause of action for providers, but instead relies on prior cases as already having established the premise as “fact”:

Recently, this Court *reiterated* the *fact* that the no-fault act creates an independent cause of action for healthcare providers when it stated, “We note that the language ‘or on behalf of’ in the release is similar to the phrase ‘or for the benefit of’ in MCL 500.3112, which this Court *has recognized* creates an independent cause of action for healthcare providers.”

Wyoming Chiropractic, 308 Mich App at 396 (emphasis added). For this proposition, the two cases quoted and cited by the Court (*Wyoming Chiropractic*, at 396 n 42) are *Mich Head & Spine v State Farm Mut Auto Ins Co*, 299 Mich App 442; 830 NW2d 781 (2013), and *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*, 250 Mich App 35; 645 NW2d 59 (2002).

In *Michigan Head & Spine*, however, the Court likewise did not analyze the statutory issue. Rather, it merely referenced the phrase “for the benefit of” in §3112 and added,

“which this Court has recognized creates an independent cause of action for health care providers.” 299 Mich App at 448 n 1, citing only *Lakeland Neurocare*.

Yet the opinion in *Lakeland Neurocare* itself, which both *Wyoming Chiropractic* and *Michigan Head & Spine* cite for the proposition that the Court of Appeals ever held that the act creates a cause of action for health care providers, *did not even address the issue*. The parties in that case “*did not dispute* that plaintiff [the provider] had the legal right to commence this action for payment of medical services rendered to defendant’s insured.” 250 Mich App at 37. The Court assumed that the provider did have a right to sue the insurer directly. Based on that assumption, the issue presented was whether the provider *also* could recover penalty interest and attorney fees under MCL 500.3142 and MCL 500.3148(1),¹ and the Court held that it could. The Court in *Wyoming Chiropractic* then turned this point entirely upside down by concluding, in essence, that since a healthcare provider *can* collect penalty interest from a no-fault insurer, it certainly must have the right to bring a cause of action to recover the underlying PIP benefits themselves. *Wyoming Chiropractic*, 308 Mich App at 397-398, relying on *Lakeland Neurocare*, *supra*.

Regents of Univ of Michigan v State Farm Mut Auto Ins Co, 250 Mich App 719; 650 NW2d 129 (2002), is also cited by the Court of Appeals as establishing the premise that a healthcare provider can assert a claim against an insured’s no-fault insurer, yet that opinion does not even cite MCL 500.3112, let alone decide whether it provides a basis for a provider

¹ “The issue, however, is whether plaintiff had the right to attempt enforcement of the penalty interest and attorney fee provisions of the no-fault act[.]” *Lakeland Neurocare*, 250 Mich App at 37-38.

to sue the insurer. The only issue addressed was whether the plaintiff, a Michigan public hospital and thus a political subdivision of the state, was subject to the No-Fault Act's 1-year back rule of MCL 500.3145(1) in light of the protection from statutes of limitations given by MCL 600.5821(4). *Id.*, 250 Mich App at 732-733.

Nor, finally, does *Moody v Home Owners Ins Co*, 304 Mich App 415; 849 NW2d 31 (2014),² support the Court of Appeals' assertion that a provider's "independent standing" to sue a no-fault insurer for benefits "is well established." The Court in *Moody* merely assumed, without citation, that such a cause of action exists; the central point of the Court's opinion was that any such right of action is not so "independent" after all:

While the providers may bring an independent cause of action against a no-fault insurer, the providers' claims against Home Owners are completely derivative of and dependent on Moody's having a valid claim of no-fault benefits against Home Owners.

Moody, 304 Mich App at 440.

The essential premise on which the challenged decision in this case stands—that "a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits" (slip op at 3)—thus is not nearly as "well settled" as the Court suggests. It is supported by nothing but precedential quicksand. Upon fresh examination as to whether there is, in fact, any statutory or common law basis for recognizing such a right, the Court will find that there is none. The Court should grant review in this case to undertake such an examination.

² Application for leave to appeal pending, sub nom *Hodge v State Farm Mut Auto Ins Co*, 497 Mich 957 (2015).

- B. Healthcare providers have no contractual basis to enforce a no-fault insurer's obligation to pay benefits because they are not intended third party beneficiaries of the insurance policy contract, and nothing in §3112 of the No-Fault Act dictates otherwise.

Never is a healthcare provider one of the contracting parties to the insurance contract between the no-fault insurer and the injured person receiving the provider's services. Accordingly, a provider would have standing to sue the insurer on the contract only if it could establish that it has rights as a third-party beneficiary to the insurance contract. Yet healthcare providers manifestly do *not* have third-party beneficiary status under the No-Fault Act. Therefore, absent an express assignment of rights from one who does have enforceable rights under the insurance contract,³ there simply is no legal basis for a provider to assert an enforceable claim against the no-fault insurer.

The purpose of the no-fault insurance system is to protect *injured persons*, or, in the case of a fatally injured person, his or her *dependents*. This has been clear since the inception of the act. *Coburn v Fox*, 425 Mich 300, 309; 389 NW2d 424 (1986); *Shavers v Attorney General*, 402 Mich 554, 596; 267 NW2d 72 (1978). Nothing in the No-Fault Act, either within the text of §3112 or otherwise, states that personal protection insurance ("PIP") benefits are payable to or for the benefit of *medical care providers*. Benefits can be paid to the injured person, and they also can be paid to a medical care provider or other third person

³ While MCL 500.3143 declares an assignment of *future* PIP benefits void, it does not prohibit an assignment of the right to claim PIP benefits already due based on expenses already incurred. *Professional Rehabilitation Assoc v State Farm Mut Auto Ins Co*, 228 Mich App 167, 172; 577 NW2d 909 (1998).

if such payment benefits the injured person, but a payment is never made for the purpose of benefitting the medical care provider or other third person.

For ease of reference, §3112 of the No-Fault Act, in its entirety, states as follows:

Personal protection insurance benefits are payable *to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents.* Payment by an insurer in good faith of personal protection insurance benefits, *to or for the benefit of* a person who it believes is entitled to the benefits, discharges the insurer's to the extent of the payments unless the insurer has been notified in writing of *the claim of some other person*. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:

- (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
- (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

MCL 500.3112 (emphasis added).

The critical flaw in *Covenant Medical*, Amici Curiae submit, is the Court of Appeals' conclusion that a healthcare provider's submission of a bill, even one accompanied by a request for payment, constitutes an enforceable "claim" for PIP benefits, thereby creating "doubt about the proper person to receive the benefits or the proper apportionment among

persons entitled thereto,” and consequently rendering the insurer’s payment of PIP benefits to the injured person not “in good faith.” *Covenant Medical*, slip op at 2. This is incorrect.

As discussed above, the Court of Appeals relied on several prior opinions for the “well-settled” rule that providers do have “independent standing” to bring claims against no-fault insurers. *Id.*, slip op at 3. These earlier opinions, in turn, to the extent they explore a legal basis for the stated proposition at all, point generally to the “*or for the benefit of an injured person*” language in the first sentence of §3112. By implication, the Court of Appeals has regarded the phrase as revealing a legislative intent to make healthcare providers intended third-party beneficiaries of the no-fault policies issued by insurers, thus granting the providers standing to sue and enforce the policies. But this manifestly is not so.

In MCL 600.1405, the Legislature explicitly defined the limited class of persons able to seek judicial enforcement of another’s contract. In pertinent part, the statute states as follows:

Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.

- (1) A promise shall be construed to have been made *for the benefit of* a person whenever the promisor of said promise has undertaken to give or to do or refrain from doing *something directly to or for said person*.

MCL 600.1405 (emphasis added). In this provision, the Revised Judicature Act addresses who can and who cannot sue in connection with a contract. Application of this limiting language to actions brought under the No-Fault Act reveals that, while certain non-

contracting parties do indeed have standing to enforce a no-fault insurer's obligations under its policy contract, healthcare providers are not among them.

In *Schmalfeldt v North Pointe Ins Co*, 469 Mich 422, 429; 670 NW2d 651 (2003), the Court confirmed that the Legislature's use of the "directly to or for" language in §1405(1) unambiguously signals that "[o]nly intended beneficiaries, not incidental beneficiaries, may enforce a contract under §1405." This conclusion is supported by the interpretive tenet of *expressio unius est exclusion alterius*, meaning that the Legislature's express mention of one thing in a statute necessarily means that it intended to exclude other similar things. *Bradley v Saranac Community School Bd of Ed*, 455 Mich 285, 298; 565 NW2d 650 (1997). Here, the Legislature thus necessarily intended that mere incidental third-party beneficiaries (or non-beneficiaries) *do not have standing* to seek judicial enforcement of a contract, such as an insurance policy, since otherwise there would have been no need for the Legislature to state that intended third-party beneficiaries do have such standing.

Nothing in MCL 500.3112 mandates that a no-fault insurer *ever* pay benefits "directly to or for" an injured person's healthcare provider. The Legislature's placement of the "to or for the benefit of" language in §3112, therefore, could not have been to make healthcare providers third-party beneficiaries of no-fault insurance policies. See *Schmalfeldt*, 469 Mich at 428.⁴ Rather, reading §3112 in conjunction with MCL 600.1405(1) makes clear that the

⁴ "A person is a third-party beneficiary of a contract only when that contract establishes that a promisor has undertaken a promise 'directly' to or for that person. ... By using the modifier 'directly,' the Legislature intended 'to assure that contracting parties are clearly aware that the scope of their contractual undertakings encompasses a third party, directly referred to in the contract, before the third party is able to enforce the contract.'" *Schmalfeldt*, 469 Mich at 428, quoting *Koenig v South Haven*, 460 Mich 667, 677; 597 NW2d 99 (1999), and MCL 600.1405(1).

Legislature’s intent in using the phrase “to or for the benefit of” in the first sentence of §3112⁵ was to mandate that *non-policyholder injured persons* and, in the case of fatal injuries, *dependents* of injured persons, be third-party beneficiaries under no-fault insurance policies and therefore be vested with standing to enforce the policy contract directly against the insurer.

Indeed, precisely because there was no such legislative boost in *Schmalfeldt v North Pointe Ins Co, supra*, the injured person in that case was unable to enforce the “medical payments provision” of the insurance contract between the defendant insurer and its commercial policyholder, the Elite Bar. The policy provided for up to \$5,000 in medical expenses payments without regard to fault for injuries occurring on the insured’s premises, but the payment of benefits was not promised “directly to or for” the benefit of the injured patron. Accordingly, while the contracting policyholder itself had the right to enforce the insurer’s obligations under the policy (it chose not to), the injured plaintiff himself had no such right:

Nothing in the insurance policy specifically designates Schmalfeldt, or the class of business patrons of the insured of which he was one, as an intended third-party beneficiary of the medical benefits provision. ...

... This agreement is between the contracting parties, and Schmalfeldt is only an incidental beneficiary without a right to sue for contract benefits. For this reason, North Pointe is entitled to summary disposition.

Schmalfeldt, 469 Mich at 429.

⁵ “[PIP] benefits are payable *to or for the benefit of an injured person or*, in case of his death, *to or for the benefit of his dependents*.” §3112 (emphasis added).

Similar to the med-pay coverage provided by the policy in *Schmalfeldt*, no-fault insurance policies likewise provide for payment of an injured person's medical expenses without regard to fault. Under the No-Fault Act, however, third-party beneficiary status is conferred upon injured persons and their dependents, which allows them, unlike the plaintiff in *Schmalfeldt*, to pursue recovery of benefits directly from the insurer. To be sure, persons who provide and charge for necessary services to injured persons derive an incidental benefit from the existence of insurance coverage applicable to the expense of their services; but while the act confers third-party beneficiary rights on injured persons, no such rights are conferred upon non-contracting service providers.

This analysis is fully supported by extensive case law from other no-fault insurance states. For instance, applying Kentucky's no-fault insurance law in *United States v Allstate Ins Co*, 754 F2d 682 (CA 6, 1985), the federal appellate court held that the plaintiff, having provided medical services to an army serviceman injured in an automobile accident but having not received an assignment of the injured person's rights, could not sue the no-fault insurer for payment. That the statute made healthcare providers optional payees did not alter this conclusion:

[I]n providing that "medical expense benefits may be paid by the [insurer] directly to persons supplying products, services, or accommodations to the claimant," [the statute] makes the provider an optional payee or incidental beneficiary of no-fault policies in order to facilitate the insured person's receipt of benefits, and does not make the provider a third party beneficiary with a right to enforce the insurance contract.

United States v Allstate Ins Co, 754 F2d at 666.

Later, in *Neurodiagnostics, Inc v Ky Farm Bureau Mut Ins Co*, 250 SW3d 321 (Ky, 2008), the Kentucky Supreme Court reached the same conclusion even after the Kentucky statute had been amended to disallow assignments to healthcare providers:

Reading [the new provision] in light of the [Motor Vehicle Reparations Act] as a whole, we conclude that a medical provider, such as LDC, is an optional payee or incidental beneficiary of the no-fault policies.^[1] And, as an incidental beneficiary, LDC has no direct right of action against the reparation obligor [insurer]. If a medical provider does not receive payment from the reparation obligor, either because benefits have been exhausted (the State Farm case) or because the reparation obligor determines that the charges were neither reasonable nor medically necessary (the Farm Bureau case), then the insured is the party that is ultimately responsible for payment. And it is the insured that has the direct right of action against the reparation obligor if he or she disagrees with the way in which his or her benefits were either paid or not paid.

We conclude that a medical provider has no standing under the MRVA to bring a direct action against the reparation obligor/insurer.

Neurodiagnostics, Inc v Ky Farm Bureau Mut Ins Co, 250 SW3d at 329 (footnoted citation omitted).

The same approach is followed in Pennsylvania under its No-Fault Motor Vehicle Insurance Act, which, like Michigan's act, does not disallow assignment of rights to benefits already accrued. In *Ludmer v Erie Ins Exchange*, 295 Pa Super 404; 441 A2d 1295 (1982), the issue presented on appeal was "whether a doctor who has allegedly rendered medical services to an insured victim of a motor vehicle accident has the right to sue an insurance company directly as a third party beneficiary of the contract between the company and its insured." 441 A2d at 1295-1296. The court said no, concluding that neither the governing

no-fault statute nor the insurance contract supported such a right (*id.*). The opinion concludes with the following apt observations:

The scheme of the No-Fault Act itself, and the contract between the parties in the instant action, certainly do not preclude direct payment to a service provider by an insurance company. Ordinarily, such a course is efficient and sensible. It is not mandated, however, and the ordinary and prudent scheme of the law of contracts is not abrogated by the No-Fault Act. *We cannot find that a service provider becomes a third party beneficiary of the contract in the instant action, and thus the real party in interest, merely upon the allegation that he has rendered services to the insured and presented a bill for those services to the insurer.*

As the lower court states, the service provider is not seriously hampered in his ability to recover monies genuinely owed him. Where the parties amicably agree to assignment of the claim, as is usual, payment will be direct and prompt. Where problems develop, the service provider may obtain judgment against the insured and institute garnishment proceedings against the insurer.

Ludmer v Erie Ins Exchange, 441 A2d at 1296 (emphasis added).

Accord, Parrish Chiropractic Ctrs, PC v Progressive Cas Ins Co, 874 P2d 1049, 1056-1057 (Colo, 1994) (“Parrish can cite no intent on the part of the legislature to create a third-party beneficiary relationship under these facts. Accordingly, we agree with both the trial court and the court of appeals that Parrish is only an incidental beneficiary of the Progressive PIP policy and, as such, is not entitled to recovery in a direct action to enforce the terms of the policy.”); *Elsner v Farmers Ins Group*, 220 SW3d 633 (Ark, 2005) (addressing issue of first impression, where no-fault auto insurer denied payment of provider’s charges on grounds of reasonableness and necessity, plaintiff chiropractor was

merely an incidental beneficiary and thus lacked standing to bring a direct action against the insurer). The same conclusions have been reached in the analogous and parallel settings of worker's compensation coverage⁶ and group health insurance policies.⁷

There simply is no contractual basis, therefore, for a healthcare provider in Michigan to claim entitlement to payment of benefits from an injured person's no-fault insurer. It remains merely an incidental beneficiary of any no-fault insurance policy, since §3112 declares that benefits are payable "for the benefit of *an injured person*" or, in the case of death, "for the benefit of *his dependents*," and not for the benefit of third-party providers.⁸

The Court of Appeals thus erred in concluding that a healthcare provider's submission of bills to a PIP insurer with a request for payment constitutes a valid and enforceable "claim" capable of creating "doubt about the proper person to receive the benefits" thereby

⁶ *Martis v Grinnell Mut Reinsurance Co*, 905 NE2d 920, 927 (Ill App, 2009) (as chiropractor was not a "person entitled to benefits" under statute and was not a third-party beneficiary of the policy, he had no standing to enforce it); *Jou v Nat'l Interstate Ins Co of Haw*, 157 P3d 561, 572 (Haw, 2007) (holding medical provider as incidental beneficiary of the employer's worker's compensation insurance policy, where the statutory scheme was designed "to compensate employees for work-related injuries, not to compensate physicians"); *Furno v Citizens Ins Co*, 590 NE2d 1137, 1141 (Ind App, 1992) (rejecting proposition that physician treating injured employee was a third-party beneficiary of worker's compensation policy).

⁷ *Kelly Health Care, Inc v Prudential Ins Co*, 309 SE2d 305, 307 (Va, 1983); *Zweig v Metropolitan Life Ins Co*, 73 Misc 2d 93; 340 NYS2d 817 (1972).

⁸ Thus, again under the *expressio unius est exclusio alterius* maxim, by identifying a particular class of persons (injured persons and dependents) as intended third-party beneficiaries able to claim benefits under a policy contract to which they are not a party, the Legislature manifestly intended that other persons, such as providers of medical services, are *not* to be regarded as third-party beneficiaries able to assert claims against the policy.

rendering the insurer's payment of benefits made in "bad faith" even though made directly to the injured person who, indisputably, was entitled to the benefits.⁹

Indeed, apart from any potential assignment issues as discussed in the preceding footnote, "doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto" arises only when there is uncertainty *as to who qualifies as a "dependent" under MCL 500.3110 or how much each dependent is entitled to receive*. Reading the balance of §3112 in conjunction with §3110 makes this clear. Under §3110(1), "doubt" can emerge as to whether a surviving spouse or minor child is a "proper person" to receive benefits if it is unclear whether they were living in the same home as the accident victim. "Doubt" also can emerge under §3110(2) over the "proper apportionment" of benefits since "the extent of [one's] dependency shall be determined in accordance with the facts." Similarly, "doubt" can emerge under §3110(3) since this subsection conditions "dependent" status on particular factual inquiries. In these circumstances, a hearing may be necessary for the circuit court to "designate the payees and make equitable apportionment" of the benefits. And notably, both of the provision's exceptions that allow for payments to be made without a hearing, §3112(a) and §3112(b), are concerned exclusively with dependents' benefits.

In short, healthcare providers and others who would seek payment for services rendered to automobile accident victims have no contractual basis to sue no-fault insurers

⁹ The only conceivable way a healthcare provider's submission of a "claim" might create "doubt" requiring a circuit court hearing under §3112 would be if the claim included written proof that the injured person had assigned his right to the provider to collect PIP benefits for the charges incurred for his care and treatment. And even then, there would only be "doubt about the proper person to receive the benefits" such as to warrant a hearing if the injured person denied the validity of the claimed assignment.

since they are neither parties to, nor intended third-party beneficiaries of, the no-fault insurance policies on which they would base their claims. While the No-Fault Act clearly does confer third-party beneficiary status on “injured persons” and “dependents” of fatally injured persons, it manifestly does *not* do so with respect to healthcare providers. The unstated assumptions to the contrary, which ultimately inform the prior Court of Appeals’ opinions on which the fiction of “provider standing to sue” rests, should be exposed in the appeal before this Court and rejected.

C. The No-Fault Act does not otherwise confer on healthcare providers a statutory cause of action against no-fault insurers for recovery of an injured person’s PIP benefits.

If a healthcare provider has no contractual basis for asserting a direct claim for benefits against a no-fault insurer, then either the provider must have a *statutory* cause of action or else it has no rights against the insurer at all. The preceding discussion shows there is no such contractual basis; the following shows that there likewise is nothing in the act conferring on providers any statutory entitlement to recover from insurers.

The section of the No-Fault Act that creates a no-fault insurer’s liability for payment of PIP benefits is MCL 500.3105(1); but it does not identify to whom the insurer is liable:

Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter.

Id. Similarly, MCL 500.3107 and MCL 500.3108 describe in detail the economic losses for which benefits “are payable” under personal protection insurance (the latter addressing

survivors' loss in the event of the injured person's death), but again the provisions do not identify to whom, or for whom, the benefits are payable.

Healthcare providers are singled out in two sections of the No-Fault Act: MCL 500.3157, and MCL 500.3158(2). Under §3157, healthcare providers are prohibited from charging more than a reasonable amount for their services and in no event more than they would customarily charge in cases not involving insurance. Under §3158(2), providers are required to produce records and reports, upon request of an insurer handling a PIP claim, regarding the injured person's history, condition, treatment and dates and costs of treatment. Neither of these sections, however, by express terms or by implication, come close to conferring on healthcare providers a cause of action against the no-fault insurer.

In contrast, several sections of the act do reveal an intent to permit injured persons (whether party to the insurance contract or not) to claim benefits from a no-fault insurer. Both §3114(2) and §3114(3) speak of persons "suffering accidental bodily injury" being "entitled" to recover benefits from the responsible insurer. MCL 500.3114(2) (the injured operator or passenger "shall receive [benefits] from the insurer of the motor vehicle"); MCL 500.3114(3) (the injured employee "shall receive [PIP] benefits ... from the insurer of the furnished vehicle").

Likewise, §§ 3114(4), (5), and 3115(1) all direct that certain injured persons "shall claim [PIP] benefits from" specified insurers by order of priority. These sections of the act, the Court has held, "constitute both entitlement provisions and priority provisions." *Belcher v Aetna Cas & Sur Co*, 409 Mich 231, 251-252; 293 NW2d 594 (1980). Nowhere in these

“entitlement” provisions, however, is there any arguable reference to healthcare providers being “entitled” to benefits under the act or being directed to “claim” benefits from any insurer.

There are isolated instances in the No-Fault Act where an affirmative right of recovery is conferred on one who is neither an injured person nor a surviving dependent of a fatally injured person; but in each such instance that right of recovery is provided only to a no-fault insurer. See, MCL 500.3114(6) and MCL 500.3115(2) (both declaring an insurer “entitled to partial recoupment” from other insurers where they share the same order of priority with respect to an injured person’s benefits); MCL 500.3177 (declaring that an insurer obligated to pay benefits for injury arising out of the use of an uninsured motor vehicle “may recover” reimbursement of such benefits from the owner of the uninsured vehicle). Again, nowhere in the No-Fault Act is a cause of action for payment or recovery of PIP benefits conferred on an injured person’s healthcare provider.

Nor, finally, does §3112 of the act confer rights on healthcare providers. As detailed in the preceding section, the opening sentence of §3112 expressly—and purposely—recognizes rights possessed by an “injured person” and, in the case of death, “dependents” of the injured person. Nothing in the provision suggests that benefits are payable “to or for the benefit of” anyone *other* than these two classes of persons.

One will search the No-Fault Act in vain looking for any provision that creates a cause of action in favor of a healthcare provider; and this leaves the provider with no rights against the insurer at all. If the provider has no statutory cause of action, and if healthcare providers

are not “intended third-party beneficiaries” so as to provide a contractual basis to sue the insurer, then there simply is no right or basis for a healthcare provider “to bring a claim against an insurer for the payment of no-fault benefits.” *Covenant Medical*, slip op at 3. If true, the house of cards on which the Court of Appeals’ holding is based collapses. The Court is urged to grant leave to appeal to examine this issue of critical jurisprudential significance.

II. “NOTWITHSTANDING ANY ARGUMENT AS TO A MEDICAL PROVIDER’S ABILITY TO PURSUE A DIRECT ACTION ON A CLAIM FOR THE PAYMENT OF NO-FAULT BENEFITS OWED BY AN INSURER, SUCH AN ACTION REMAINS DEPENDENT ON THE INSURER BEING OBLIGATED TO PAY BENEFITS TO THE PROVIDER ON BEHALF OF THE INSURED.”

In granting summary disposition for Defendant State Farm, the circuit court in this case declined to resolve the threshold question of whether healthcare providers could ever have a viable claim against an insurer independent of the injured person’s claims. Instead, it determined that the Release executed by the injured person was dispositive, for the concise reason quoted above as the point-heading to this argument. (Opinion and Order of the Court, 5/15/2014, p. 4) (submitted as Exhibit B to State Farm’s Application for Leave to Appeal).

The circuit court held that State Farm was free of any potential liability based on the insured’s release of all claims, finding support in *Moody v Home Owners Ins Co*, 304 Mich App at 440 (Opinion and Order of the Court, p. 6 -- “the providers’ claims against [the insurer] are completely derivative of and dependent on Moody’s having a valid claim of no-fault benefits against [the insurer]”) (quoting *Moody, supra*). It determined “that an injured

party may waive claims for no-fault benefits owed on his behalf under the party's contract of insurance and that the provider is bound by that release." *Id.*

The court also examined MCL 500.3112 to determine whether the "[p]ayment by [the] insurer ... discharge[d] the insurer's liability," but concluded that the statutory issue was moot in light of the release of claims: "As the settlement and release discharges State Farm from liability in this matter, it is unnecessary to consider whether or not State Farm would *also* be discharged from liability by operation of §3112 even if there was no settlement and release." (Opinion and Order of the Court, p. 7) (emphasis added).

As the following will show, the circuit court's analysis is entirely correct, while the Court of Appeals' rejection of the analysis is defective on its face.

By its terms, §3112 extends a protection to the insurer—an assurance—allowing the insurer to issue a payment of benefits and know, subject to the stated limitation, that it has discharged its liability with respect to those benefits:

***Payment** by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.*

MCL 500.3112 (emphasis added). The statute speaks only of liability being discharged by mere payment. "Payment," notably, is itself recognized as a defense to claims—indeed, it is among the affirmative defenses included in MCR 2.111(F)(3)(a), as are the *separate* affirmative defenses of "release" and "satisfaction."

Under §3112, when an insurer issues a payment of PIP benefits in good faith to the injured person or for the benefit of the injured person, it can validly maintain that it has

discharged its liability; but this assurance is limited by the caveat stated in the provision's "unless" clause. By its terms, the clause takes back §3112's assurance of discharge if the insurer has written notice of someone else's claim for those. The "unless" clause, in other words, is nothing more than an exception to the stated rule that an insurer's "payment," by itself, discharges the insurer's liability as a matter of law.

Manifestly, a different issue is presented if the insurer has more to rely upon than its mere "payment" of benefits. For instance, suppose that a trial between the insurer and the injured person results in a verdict against the insurer, after which payment is made solely to the injured person pursuant to the judgment. For that matter, suppose, alternatively, that the parties resolved their dispute amicably with a consent judgment—whether under the case evaluation procedures of MCR 2.403(M)(1) or otherwise—after which the insurer issues payment solely to the injured person. Under either circumstance, the insurer would be assured that its liability was discharged based not on §3112 and the mere fact of its "payment" but on its Satisfaction of Judgment (see, MCR 2.620). If anyone in privity with the injured person thereafter attempted to assert an already existing claim, based on the insured's PIP coverage for the same accident, the insurer would have no need to rely on §3112 as the claim would be barred by *res judicata* (i.e., the affirmative defense of "satisfaction").

Indeed, since a voluntary dismissal with prejudice acts as an adjudication on the merits for *res judicata* purposes,¹⁰ the same point applies where an insurer agrees to settle a litigated

¹⁰ *Limbach v Oakland County Rd Comm*, 226 Mich App 389, 395-396; 573 NW2d 336 (1997).

claim with the injured person and the case is dismissed with prejudice. Accordingly, if, *as in the case at bar*,¹¹ a no-fault insurer pays its insured PIP benefit monies in settlement of a disputed claim in exchange for a dismissal of the action and a comprehensive Release of all claims, it would have no need to rely on §3112's "discharge of liability" in the event someone thereafter were to assert a derivative claim against the insurer. As the circuit court held, the release covering existing and future claims for benefits remains enforceable against one who would rely on the injured person's entitlement to benefits, such as a medical provider (Opinion and Order of the Court, p. 6). The insurer's liability in such instance is discharged both by "release" and *res judicata*.

In short, when an injured person's claim is resolved by a judgment (consent or otherwise), an order of dismissal with prejudice, or a release of claims, the insurer's mere "payment of benefits" is not, and need not be, the basis on which the insurer's liability is deemed discharged. The "unless" clause of §3112 on which the Court of Appeals relied simply has no application since its function is solely to limit the breadth of a discharge by "payment."

The Court of Appeals' analysis in this regard is patently flawed. Citing §3112 (indeed, purporting to rely on its "plain text"), the opinion states that when an insurer has written notice of a third party's claim, the insurer cannot discharge its liability "by settling

¹¹ The record shows that State Farm's payment of benefits in exchange for a release of claims from its insured, Jack Stockford, occurred in a litigated action, *Stockford v State Farm Mut Auto Ins Co*, Tenth Circuit Docket No. 12-016370-CK, which presumably was "resolve[d]" by entry of a dismissal with prejudice. See Opinion and Order of the Court, p. 1 (Exhibit B to State Farm's Application for Leave to Appeal).

with its insured.” *Covenant Medical*, slip op at 2. The statute, however, does not say this. It provides only that liability is not discharged *simply by making a payment*. It does not purport to address settlement of claims.

The opinion proceeds to announce, even more explicitly, that where there is written notice of a provider claim, §3112 dictates that a “payment *and release* does not extinguish the provider’s rights” (slip op at 3) (emphasis added); that, unless the insurer complies with §3112, “an insured’s *agreement to release the insurer* in exchange for a settlement, does not release the insurer as to the provider’s noticed claims” (*id.*) (emphasis added). Again, the opinion’s statements are utterly unsupported by the text of the statute. While the “unless” clause of §3112 operates to erase an insurer’s “discharge[.]” of liability otherwise gained by its mere payment of benefits, that is as far as it goes. It does not purport to invalidate a release that would discharge the insurer from all liability arising out of the insured person’s injury.

The holding of the Court of Appeals thus effectively transforms the “unless” clause of §3112 from a limitation on the scope of the preceding “payment” provision to an affirmative grant of immunity on the part of healthcare providers from the defenses of “release” and *res judicata*. Under the court’s opinion, the hearing procedures identified in §3112 not only apply when an insurer attempts to meet its obligations by issuing a payment of benefits but are imposed on any transaction that *includes* payment of monies by the insurer, including negotiated settlements in exchange for a release of claims and payments made in satisfaction of a judgment.

The Court should grant review in this case and conclude, ultimately, that §3112, by its very terms, only defines the extent to which a simple “payment” of PIP benefits operates to discharge the insurer’s liability; the Court should conclude that §3112 provides the no-fault insurer with assurance that it can issue payment to or for the benefit of the injured person and, subject to the stated exception, know that it has discharged its liability to the extent of the payment. By extending to insurers this assurance of a “safe method” for paying benefits, the statute advances the act’s purpose of promoting prompt payment of benefits. *Miller v Auto-Owners Ins Co*, 410 Mich 538, 568; 302 NW2d 537 (1981), citing *Shavers v Attorney General*, 402 Mich at 578-579. It does not, however, eliminate the effect of a valid release agreement or the conclusive effect of a judgment or an order of dismissal with prejudice.

The Court should conclude, in other words, that the circuit court got it right. Once the injured person resolved its dispute with the insurer and executed a valid release of all claims, no insurance benefits remained payable to or for the benefit of the injured person. The release ended the insurer’s obligation to pay benefits under its contract of insurance. (Opinion and Order of the Court, p. 4).

CONCLUSION

The issues raised in Defendant STATE FARM’s Application for Leave to Appeal warrant this Court’s review. The premise that an injured person’s healthcare provider “has independent standing to bring a claim against an insurer for the payment of no-fault

benefits,” on which the viability of the Court of Appeals’ decision depends, is unfounded and insupportable. It is an issue that has thus far escaped Supreme Court review. The devastating effects of the challenged Court of Appeals decision in this case, however, dictate that its time for review has arrived.

Furthermore, even if one were to accept the premise that healthcare providers have standing to sue for payment of an insured’s no-fault benefits, the Court of Appeals’ holding nevertheless cannot survive from an analytical standpoint; nor should it survive, given the adverse impact the newly imposed procedures have on parties’ ability to resolve no-fault claims efficiently and with a minimum of judicial intervention.

Amici Curiae, IIM and MIC, therefore, respectfully urge the Court to grant Defendant-Appellant’s application for leave to appeal in this matter, and ultimately to reverse the judgment of the Court of Appeals for the reasons stated herein.

Respectfully submitted,

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April 26, 2016

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**STATE OF MICHIGAN
IN THE SUPREME COURT**

COVENANT MEDICAL CENTER,

Plaintiff-Appellee,

Supreme Court No. 152758

v.

Court of Appeals No. 322108

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY, a Michigan
insurance corporation,

Saginaw County Circuit Court
No. 13-020416-NF

Defendant-Appellant.

PROOF OF SERVICE

DANIEL S. SAYLOR certifies that he is associated with the law firm of GARAN LUCOW MILLER, P.C., attorneys for Amici Curiae, INSURANCE INSTITUTE OF MICHIGAN and MICHIGAN INSURANCE COALITION, and that on April 26, 2016, he served the **Brief of Amici Curiae, Insurance Institute of Michigan and Michigan Insurance Coalition, in Support of Defendant-Appellant's Application for Leave to Appeal**, and this **Proof of Service**, upon the parties and amicus curiae Auto Club Insurance Association, by directing the Court's *TrueFiling* system to deliver true copies via "e-Service" to:

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